Formal Complaint Regarding Conduct of [redacted]

Ministry of Children and Family Development

Complainant: Darian Thomas
Child: Bennett James Thomas
Timeline Covered: July – October 2025

Background

I am the mother and legal guardian of my son, Bennett James Thomas — a six-year-old autistic child with complex medical and developmental needs, including G-tube feeding and chronic gastrointestinal illness. Bennett has lived solely in my care since birth.

In 2020, the Supreme Court of British Columbia issued a Final Family Law Order confirming that I am Bennett's primary guardian and full-time residential parent. The order granted Bennett's father supervised access only, based on ongoing safety concerns and the recommendations of multiple professionals who had assessed our family circumstances. Since that time, Bennett's father's contact has remained limited and supervised, in accordance with the court's direction and consistent with established safety plans developed by both MCFD and Bennett's clinical team.

For years, the status quo has reflected Bennett's clear need for stability, predictability, and the presence of trusted caregivers familiar with his medical and developmental profile. All of Bennett's care coordination, medical decision-making, and daily support have been managed by me, with his professionals confirming that this structure provides him with the consistency and emotional security essential to his well-being.

On July 26, 2025, I was hospitalized for a medical emergency. Following direct guidance from the MCFD screening line, Bennett was admitted to BC Children's Hospital (BCCH) under medical and behavioural supervision, with the clear understanding that discharge would occur through a family-led plan coordinated with his existing professionals.

In the months before my hospitalization, I repeatedly warned MCFD Children and Youth with Support Needs (CYSN) social workers, whom I had been in close contact with the past two years, that my health could require inpatient treatment and begged them to put an emergency care plan in place for Bennett. Each time, I was told, "we'll cross that bridge when we get there."

This complaint addresses the conduct of MCFD social worker [redacted], who managed Bennett's case from July to October 2025. Her actions — and those of her

supervisors, [redacted] and [redacted] — breached the *Child, Family and Community Service Act (CFCSA)*, MCFD Service Delivery Policies, and the *Public Service Values and Conduct Policy.* These failures directly endangered Bennett's physical safety, compromised his medical stability, and caused deep, ongoing emotional harm.

August 2025 – Misconduct Surrounding Hospital Removal

Despite multiple written medical opinions from Bennett's psychiatrist, counsellor, and behaviour consultant warning that discharge to untrained caregivers would put him at serious risk, MCFD social worker [redacted] and her supervisor [redacted] authorized Bennett's apprehension on August 28, 2025. They removed him from my care while he was still admitted at BC Children's Hospital, before I was discharged, and before his interim guardian, Dylan [redacted], could complete Bennett's formal discharge process later that same afternoon.

This decision disregarded a valid Standby Guardianship Form naming Dylan as Bennett's guardian during my temporary medical incapacity and directly contradicted written recommendations from Bennett's medical and behavioural teams against placement with untrained caregivers.

MCFD placed Bennett in a resource home [redacted] where staff had no G-tube or behavioural care training for children under twelve. Immediately following his removal, Bennett's long-term therapeutic team was barred from all contact, and I was denied communication with both my son and his clinicians for an entire week — a clear violation of CFCSA s.70(1)(a) and (f), which guarantee a child's right to family connection and medical care.

This removal:

- Ignored a valid Standby Guardianship Form and a pending Supreme Court order under the Family Law Act, which was later granted on September 2, 2025.
- Violated CFCSA *s.2*, *s.5.1*, and *s.30*, which require the Ministry to use the least intrusive, family-led measures; and
- Denied Bennett his rights under *s.70(1)(a)* and *(f)* — the right to maintain contact with family and to receive adequate medical care.

During this same period, [redacted] and [redacted] informed Bennett's father that if he obtained a Family Law Order, he could assume Bennett's primary residence in the United States, where he currently lives — despite existing supervised-access arrangements and long-standing safety plans outlining documented risk.

September 2025 – Communication Restrictions, Safety Failures, and Retaliatory Conduct

a. False Allegations and Premature Guardianship Assumption

While I was hospitalized, [redacted] and [redacted] conducted two interviews at [redacted] Hospital, during which they made false claims of neglect — including allegations that I wasn't feeding or bathing Bennett. These claims directly contradicted documented sensory-care routines and multiple medical letters from the West Coast Feeding Team and BCCH, which clearly identified Bennett's feeding challenges as physiological, not neglect-based.

During the second interview, [redacted] stated that the Ministry had already **"**assumed temporary guardianship**"** before the conversation had even concluded — a clear indication that the decision to remove Bennett had been predetermined, without lawful process, in violation of CFCSA s.30(2) (procedural fairness).

b. Restricting Contact and Emotional Support

After Bennett's removal, MCFD issued a written "NO CONTACT" directive against all family members and blocked Dylan [redacted] from receiving the G-tube training he was lawfully entitled to as Bennett's designated guardian. This decision undermined guardianship authority and violated CFCSA s.70(1)(a) and (f)**,** which protect a child's right to family connection and proper medical care.

Bennett's iPad — his only means of communication — remained offline until September 10, 2025, even though contact had been officially authorized on September 5. When FaceTime calls finally resumed, Bennett told me, *"It's scary for me out there,"* and kept asking me to *"pick him up."*

Between September 12–17, 2025, [redacted] implemented new **"**no-comfort" visitation rules that:

- Limited FaceTime to one hour per day;
- Prohibited any discussion about Bennett's health or feelings;

- Required scripted responses such as, *"Thank you for sharing that; let's tell staff"*; and
- Barred advocates or family members from attending visits.

Professionals including [redacted], [redacted], and FSIBC Director [redacted] all opposed these restrictions, warning that they would severely destabilize Bennett emotionally**.** These actions violated CFCSA s.70(2**)** and the MCFD Family Contact Policy, which mandate that contact be maintained in ways that support a child's well-being.

c. Ignoring Physical Harm and Suppressing Reports

At my September 13, 2025 in-person visit, I saw unexplained bruises on Bennett's arms and legs. I reported them immediately to the MCFD provincial screening line and to my advocates. The screener told me to "bring it to your assigned worker," [redacted]—refusing to take the report through the provincial channel I had called on purpose. That pushed the concern back to the very worker whose conduct I was raising, stripping the process of neutrality and basic integrity.

No timely medical exam or incident report followed, in breach of Policy 6.8 (Critical Incidents). On September 15, advocate [redacted] warned MCFD in writing that failure to initiate a medical evaluation would itself constitute neglect under the CFCSA**.**

The next day, September 16, [redacted] emailed me—copying [redacted]—to cancel all in-person visits and push access to a third-party agency, citing "concerns raised by your advocate." That was retaliation, not child-centred practice. Internal records later confirmed [redacted] first learned about the bruising from me, and no internal critical-incident report was filed—another violation of Policy 6.8**.**

This sits in a pattern: safety concerns raised through proper channels were redirected, minimized, or punished instead of investigated.

d. Suppressing Comfort Items and Therapies

Under [redacted] direction, [redacted] House staff delayed giving Bennett his comfort and sensory items — his *"Mommy blanket,"* stuffed owl *Fluffy,* tubie covers, and adhesive wipes. These delays caused unnecessary pain and distress, worsening both his G-tube irritation and emotional regulation.

Since Bennett's removal, MCFD has suspended all of his counselling and behavioural therapy and unilaterally switched his long-term paediatrician, cutting off continuity of care.

This disregard violates CFCSA s.70(1)(f) and the Integrated Practice and Collaboration Policy, both of which guarantee a child's right to consistent, coordinated medical and therapeutic support.

e. Interfering with Guardianship and Education

Despite a valid Interim Guardianship Order issued by the Supreme Court on September 2, 2025, granting authority to Dylan [redacted], MCFD refused to recognize it. Principal [redacted] at Fawkes Academy confirmed that Bennett was *actively enrolled and funded* at the time of his removal.

Even so, MCFD falsely claimed that Bennett had "not attended school for 18 months" and incorrectly stated he was "entering Grade 2" — both entirely untrue.

Staff at Fawkes Academy and multiple advocates documented that MCFD's decision to transfer Bennett to [redacted] was financially motivated — an attempt to offload costs from MCFD to the public school system. This directly contravenes Service Delivery Policy 5.4 (Educational Stability) and CFCSA s.70(1)(b), which protect a child's right to participate in educational decisions and maintain consistent supports.

By September 24, MCFD had enrolled Bennett at [redacted] without consultation, effectively cutting him off from his specialized autism supports. Despite Dylan [redacted] signing the special education funding forms with Fawkes Academy to confirm Bennett's ongoing enrollment, MCFD overrode the decision, disregarding both court authority and the child's best interests.

f. Misuse of Confidential Information

During an unannounced home visit on September 18, [redacted] and [redacted] admitted that undisclosed "child protection reports" had come from my mother—someone with a known history of false allegations and mental health concerns. These unverified claims were treated as fact and used to justify Bennett's removal and subsequent restrictions, violating the Public Service Values of integrity and accountability.

During this same period, MCFD accessed my personal medical records under CFCSA s.96 without notice or consent. This was a serious breach of privacy and confidentiality, one that has left me hesitant to follow up with my medical specialists out of fear that my private health information could again be misused.

October 2025 – Continued Misrepresentation and Safety Neglect

On October 10, [redacted] issued a draft Family Plan—well past the 30-day requirement under CFCSA s.93.1. The document contained multiple false statements, including that I had left Bennett "awake and unattended," and excluded critical medical information that had been verified by BC Children's Hospital. It also listed goals for Bennett without consulting any of the professionals directly involved in his care.

After issuing the plan, [redacted] tried to schedule a meeting to "go over it," insisting that the goals outlined would have to be completed before reunification could occur. Neither I nor my lawyer have ever been given access to the evidence or rationale behind those goals, despite repeated written requests for full disclosure since Bennett's removal. This lack of transparency and failure to consult with involved professionals violates CFCSA s.5.1, which guarantees family involvement, as well as the Public Service Values Policy, which requires fairness, respect, and accountability.

[redacted] later asked me to sign the Family Plan—which contained misinformation and unsupported claims—before I had been given access to any of the evidence behind those statements. She made this request the day before confirming that disclosure for the file would be made available. Following the advice of my legal counsel, I stated that I would not sign the plan until full disclosure was provided. The Ministry advised that disclosure would be ready by October 24, 2025, yet despite repeated requests from my counsel since Bennett's removal, it was not delivered on the anticipated date.

[redacted] later attempted to arrange the Family Plan meeting but said I could not bring advocates or legal counsel, allowing only herself and [redacted] to attend. After I challenged the legality of this restriction, [redacted] eventually confirmed my lawyer could attend—and that they would bring their own—but still prohibited any advocates or support people, citing "confidentiality." This was despite the fact that I had already signed Consent to Disclose and Consent to Collect forms for my advocates on September 18, 2025.

The September 4 Report to Court, written jointly by [redacted] and [redacted], contained numerous false and misleading statements about Bennett's medical care, home environment, and behavioural supports. It failed to acknowledge the consistent written recommendations from his treating team—including his psychiatrist, counsellor, and behaviour consultant—all of whom had clearly warned against placing him with untrained caregivers.

The report also omitted any mention of my written correspondence to both MCFD and BC Children's Hospital in early August 2025, confirming that I had already arranged medically trained in-home supports and appointed an interim guardian for Bennett's discharge.

MCFD's refusal to correct these misrepresentations, even after receiving notice from multiple credible professionals, violates Service Delivery Policy 1.4 (Accuracy and Integrity of Documentation) and the Public Service Values Policy (Honesty and Accountability).

When my lawyer and I formally asked that the September 4 report be corrected or withdrawn, [redacted] responded that "the report cannot be changed once submitted," despite the fact that several professional letters and factual clarifications had already been provided. Subsequent correspondence from me, my lawyer, and my advocates reiterated the documented errors and requested an addendum or clarification to ensure the Court received accurate information. Those requests were ignored.

The Ministry's continued reliance on a report it knew contained false statements—while refusing to acknowledge or disclose verified corrections—undermines the fairness of the judicial process and directly violates CFCSA s.2(e), which requires that all decisions affecting a child be based on accurate, balanced, and complete information. This deliberate inaction allowed misinformation to stand before the Court and further eroded my ability to participate meaningfully in Bennett's case planning and defense.

On September 30, I reported new safety concerns about exposed wiring in Bennett's play area at [redacted] House. Instead of being inspected or documented, the wires were simply covered with tape—an obvious violation of MCFD's Health and Safety Standards for Resource Homes.

Throughout October, [redacted] continued to withhold essential information and misrepresent Bennett's well-being. The first update I received from her about his care was not until October 8, 2025—more than five weeks after his removal on August 28. She repeatedly stated that supervised visits were "going really well," yet refused to provide copies of the visit reports to me or my lawyer.

By controlling all communication channels while denying access to documentation about my own child's care, MCFD made it impossible for me to understand how Bennett was adjusting or to raise timely concerns about his safety and emotional state. This lack of transparency directly contravenes CFCSA s.70(1)(b), which guarantees a parent's right to participate in and be informed about their child's care.

On October 20, Bennett appeared with new bruising, yet MCFD failed to initiate a medical evaluation or file a report under the Critical Incident Policy. My FaceTime videos from October 19–20 clearly show visible bruises on his arms and legs, but both [redacted] and [redacted] House staff claimed they only noticed them on October 21—creating a clear and concerning discrepancy in timelines.

During the October 22 meeting with RCY advocate [redacted], [redacted] admitted that the bruises were “in the same locations as the last ones” but said she didn’t believe a medical assessment was necessary, citing a previous pediatric opinion that called similar bruises “typical injuries from play.” She stated she would conduct a “full body assessment” herself and send photos to her director, but no medical professional was ever involved.

The documentation from the [redacted] Clinic, which [redacted] referenced to justify her decision, has never been disclosed to me or my lawyer—meaning her claims cannot be verified. This lack of transparency and failure to follow critical-incident protocol raise serious concerns about the accuracy of her reporting and MCFD’s compliance with its own policies.

Later that day, [redacted] sent a “post-meeting update” by email, stating that she had personally assessed Bennett, observed only a “faded bruise the size of a quarter,” and determined that “no further medical assessment [was] necessary.” Her conclusion directly violated MCFD’s Critical Incident Reporting Policy, which requires a physician’s evaluation for any unexplained bruising on a vulnerable child in care. The bruises appeared on the same limbs as before, suggesting a possible pattern of injury that clearly warranted medical review.

During my visit with Bennett on October 21, I personally observed a bruise on his arm near the elbow, another on his hip, and several marks below his knee—matching what I had already seen on video two days earlier. None of these details appeared in [redacted] report.

MCFD’s ongoing minimization of these injuries—combined with conflicting accounts between staff and the social worker—constitutes a breach of CFCSA s.70(2)(a), which protects a child’s right to safety. It also reflects a continued failure to ensure proper medical accountability for a child under the Director’s care.

Throughout this period, [redacted] continued to share case information with Bennett’s father, despite his supervised-contact order and lack of guardianship, while excluding me from key meetings and updates about my son’s care. She also failed to ensure proper management of Bennett’s G-tube while he has been under the Director’s care.

Records show she ignored repeated concerns from both me and Bennett’s long-time G-tube nurse, [redacted], about worsening granulation tissue around the stoma. Despite visible irritation and my written note that the site “has never looked as bad as it does now,” [redacted] relied on casual reassurances from non-specialist providers and failed to coordinate appropriate follow-up with [redacted] at BC Children’s Hospital.

This neglect has caused Bennett ongoing pain and discomfort. Untreated granulation tissue can lead to leakage, infection, and delayed healing—risks that should never have been ignored for a medically complex child. The absence of a documented plan to treat or monitor the issue reflects a serious breach of MCFD's duty under CFCSA s.70(2)(a), which protects a child's right to adequate medical care and safety, and violates MCFD's own policy standards for medical coordination and continuity of care.

Professional Consensus Ignored and Retaliatory Conduct

Every professional directly involved in Bennett's care—Dr. [redacted] (psychiatry), [redacted] (counselling), [redacted] (BCBA), and [redacted] (public-health nurse)—provided written warnings that abruptly separating him from his primary caregiver and familiar, trained team would be dangerous.

Instead of following that guidance, MCFD barred his behavioural team from their scheduled shifts and physically escorted [redacted] off hospital grounds during an active therapy session, immediately after Bennett's removal. This act of retaliation not only disregarded professional recommendations but also directly destabilized Bennett's medical and emotional well-being.

Ongoing Impact

Bennett's stability has declined significantly since his removal.

- His counselling and behavioural therapy have been discontinued.
- His G-tube complications have worsened.
- His anxiety has increased, and his sleep has become disrupted.
- His schooling and daily routine have been destabilized.
- His voice—and his rights under CFCSA s.70—have been ignored.

The cumulative pattern of misconduct by [redacted] reflects a systemic disregard for:

- CFCSA s.2 and s.5.1, which require least-intrusive, family-led and child-centred planning;
- CFCSA s.70, which guarantees a child's rights to family connection, participation, and medical care;
- MCFD Service Delivery Policies, including those governing family contact, incident reporting, education, and case planning; and

- Public Service Values and Conduct, which demand integrity, respect, and accountability.

The overall result is that Bennett—a medically complex, autistic child—has been placed in a system that has failed to protect his physical safety, emotional health, and developmental stability.

Oversight and Human Rights Actions

To ensure accountability, I have taken every possible formal step.

- *BC Ombudsperson Complaint* [redacted] – outlining systemic failure and retaliation by MCFD;
- *Patient Care Quality Office (PCQO) files* [redacted] – documenting failures in discharge planning and nursing oversight;
- *BC Human Rights Tribunal* [redacted] – addressing discrimination based on family status and disability.

I have also provided full documentation to MLAs [redacted], CTV News, RCY advocate [redacted], and Inclusion BC. Each confirmed that every internal remedy had already been exhausted before these escalations were made.

In addition, I contacted the Ministry's complaint specialist directly regarding these ongoing issues, but I have not received any follow-up or communication since the end of September 2025. The continued lack of response from MCFD's own oversight branch speaks volumes about the absence of accountability within this system.

Requested Outcomes

I am requesting that MCFD take the following actions to address these ongoing violations and restore Bennett's safety, rights, and stability:

1. Conduct a full and transparent investigation into the actions of [redacted], [redacted], and [redacted] between July and October 2025.
2. Facilitate Bennett's safe and immediate return home to his primary caregiver, consistent with CFCSA s.2(b) (family preservation and reunification) and s.70(1)(a) (right to family connection and continuity of care). The evidence clearly shows that I remain the safest, most consistent, and medically capable caregiver for my son.
3. Verify compliance with the CFCSA and MCFD Service Delivery Policies, and document all deviations.

4. Correct or suspend the false information contained in both the September 4 Report to Court and the October Family Plan.
5. Investigate the unreported incidents—including the September and October bruising and wiring hazards—for non-compliance with Policy 6.8 and CFCSA s.14.
6. Review the legality of MCFD's access to my medical records under CFCSA s.96 and FOIPPA.
7. Reinstate Bennett's therapeutic services and family contact in alignment with CFCSA s.70(1).
8. Disclose all supervision reports and full file contents, then develop a corrected Family Plan in collaboration with my legal counsel and Bennett's professional care team.
9. Implement disciplinary and systemic remedies, including staff training on complex-needs case management, trauma-informed practice, and statutory child rights.

These steps are necessary not only to correct the harm that has already occurred but to ensure no other child or family is put through the same violations of policy, law, and basic human decency.

Despite five formal letters from my legal counsel addressing the ongoing concerns about Bennett's care and the conduct of the social workers involved in this file, nothing has been resolved. I have been Bennett's primary caregiver since birth. Hundreds of pages of medical records, professional assessments, and letters of support have been submitted to MCFD confirming my ability to meet his complex needs safely and consistently. This removal was not based on solid evidence—it was a deeply flawed decision that ignored expert input, documentation, and the clear best interests of my son.

Sincerely,
Darian Thomas
Parent and Legal Guardian of Bennett James Thomas